

SECTION 1

Targeted Case Management Overview

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TARGETED CASE MANAGEMENT OVERVIEW

Pursuant to the Welfare and Institutions Code, Section 14132.44, targeted case management (TCM) became a covered Medi-Cal benefit effective January 1, 1995. TCM consists of case management services that assist Medi-Cal-eligible individuals within specified targeted groups to access needed medical, social, educational, and other services. TCM service components include needs assessment, setting needs objectives, individual services planning, service scheduling, crisis assistance planning, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal-eligible person are addressed on an ongoing basis and appropriate choices are provided from the widest array of options for meeting those needs.

As the single State agency administering the federal Medicaid program in California, the Department of Health Services (DHS) has secured approval for amendments to the California State Plan to include TCM as a covered service under the Medi-Cal program. Each State Plan Amendment (SPA) for TCM specifies the target population, the geographic area to be served, the provider qualifications, the definition of covered services, the unit of service, and the reimbursement methodology. Unlike other Medi-Cal services, TCM services do not need to meet the requirements of “statewideness” or “comparability.” This means that TCM may be provided to a broad segment of the population or be limited to a certain group within a certain geographic area or political subdivision. LGAs that elect to participate in the TCM program will be included in the SPA and provide the TCM services contained in the California State Plan.

Case management services are provided to six defined target populations. These target populations are defined in the California State Plan by “age, type or degree of disability, illness or conditions, or any other identifiable characteristic or combination thereof.”

TCM providers are limited to Local Governmental Agencies (LGAs) under contract with DHS to provide TCM services, and are identified in the California State Plan. The State Plan is a comprehensive written document describing the nature and scope of California’s Medicaid program. The federal Centers for Medicaid and Medicare Services (CMS) must approve the State Plan before federal financial participation will be reimbursed to the State. LGAs may subcontract with nongovernmental entities or the University of California, or both, to provide TCM services on its behalf.

Pursuant to the California Code of Regulations (CCR), target populations eligible to receive TCM services consist of the following Medi-Cal beneficiary groups:

High- risk persons as defined in Section 51185(c) of the CCR.

Persons who have language or other comprehension barriers. These are persons who:

Are unable to access or appropriately utilize services themselves, have demonstrated noncompliance with their medical regimen; and are unable to understand medical directions because of language or other comprehension barriers; or have no community support system to assist in follow-up care at home.

Persons who are 18 years of age and older and who:

Are on probation and have a medical and/or mental condition; have exhibited an inability to handle personal, medical, or other affairs. Have exhibited an inability to handle personal, medical, or other affairs; are under public conservatorship of person and/or estate; have a representative payee; are in frail health and in need of assistance to access services in order to prevent institutionalization.

These Medi-Cal beneficiary groups correlate with six distinct TCM populations: (1) Public Health, (2) Outpatient Clinics (Clinics) , (3) Aging and Adult Services/Linkages, (4) Public Guardian/Conservator, (5) Adult Probation, and (6) Community. Section T.2 of this manual defines the qualifications for the provider agency and case managers.

A claim for TCM is based on an encounter. Pursuant to Section 51185(b) of the CCR, an encounter for Public Health, Aging and Adult Services/Linkages, Outpatient Clinics, and Community Programs is defined as “a face-to-face contact or a significant telephone contact in lieu of a face-to-face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more TCM service components by a case manager. An encounter for Public Guardian/Conservator Program is defined as a face-to-face encounter or significant telephone contact with or on behalf of the Medicaid-eligible person for the purpose of rendering one or more TCM service components by a case manager.

Each year, DHS designates a month in which LGAs will participate in a TCM Time Survey. The month of the time survey may vary to ensure a valid basis from which to project current fiscal year costs. The time survey determines the percentage of each LGA’s time that was spent providing TCM services. Information from the time survey is then aggregated into an annual cost report prepared for each program and submitted to DHS by the LGA.

Pursuant to Section 51535.7 of the CCR, the annual cost report is submitted to DHS by November 1 of each year. The cost report reflects only the allowable direct and indirect costs of providing TCM services. Actual allowable costs and encounter data from the prior fiscal year determines the annual, program-specific, per-encounter reimbursement rate for the current fiscal year. A per-encounter reimbursement rate is calculated by dividing the reported TCM costs by the total number of all Medi-Cal and non-Medi-Cal encounters in the prior fiscal year. The total dollar amount an LGA may claim in the current year is capped. The cap is the product of the projected number of Medi-Cal encounters for the current fiscal year multiplied by the billable rate per encounter. Any costs in excess of the cap are recognized in the annual cost report and become part of the calculation in determining the billable rate per encounter for the subsequent fiscal year. TCM encounters are reimbursed at the Federal Medical Assistance Percentage.

LGAs must have a current signed TCM Provider Agreement to submit a TCM claim. DHS prescribes the format required to submit TCM claims. Each claim must be accompanied by a corresponding TCM Summary Invoice, signed by the MAA/TCM Coordinator or their designee. Claims may be submitted monthly, or quarterly, but not more than six months after the month in which the TCM service is rendered, pursuant to CCR Section 14115 to receive 100% reimbursement. Claims submitted between 7-9 months after the month of service will be reduced by 25 percent, and claims submitted between 10-12 months after the month of service will be reduced by 50 percent.

Payment for TCM services must not duplicate payments made to public agencies or private entities under other program authorities for the same purposes (e.g., case management services provided must not duplicate case management services provided under any home and community-based services waiver). LGAs must implement a countywide system to prevent duplication of services and to ensure coordination and continuity of care among TCM providers to individuals eligible to receive case management services from two or more programs.